## TB PREVENTION MEDICAL EVALUATION

Name:	DOB:
TB PPD test date:	Result: mm
Chest x-ray date:	(This patients x-ray report, with "normal" findings and taken within the last 6 months, should accompany this form).
Attention Medical Care Provider:	
Please evaluate this patient for TB prevention therapy, complete the following questions and return this form to the patient.	
TB Preventive therapy is recommend	led for months.
TB Preventive therapy is recommended by was refused by patient.	
TB Preventive therapy is NOT recommended because	
	of treatment completed on
Previous TB infection	date
Provider Name:	Date: